MARYLAND DUAL ELIGIBLES CARE DELIVERY INITIATIVE

STAKEHOLDER WORKGROUP - NOVEMBER 15, 2016

AGENDA

- Care Management Roles and Responsibilities for D-ACO and PCHH
- Beneficiary Counseling
- Quality Measurement
- Risk Adjustment Methodology
- Next Steps – Stakeholder Engagement Process

THEORY OF CHANGE CHARACTERIZED IN DRIVER DIAGRAM

Goal

Achieve and Sustain High-Value Coordinated Care for Dual Eligibles

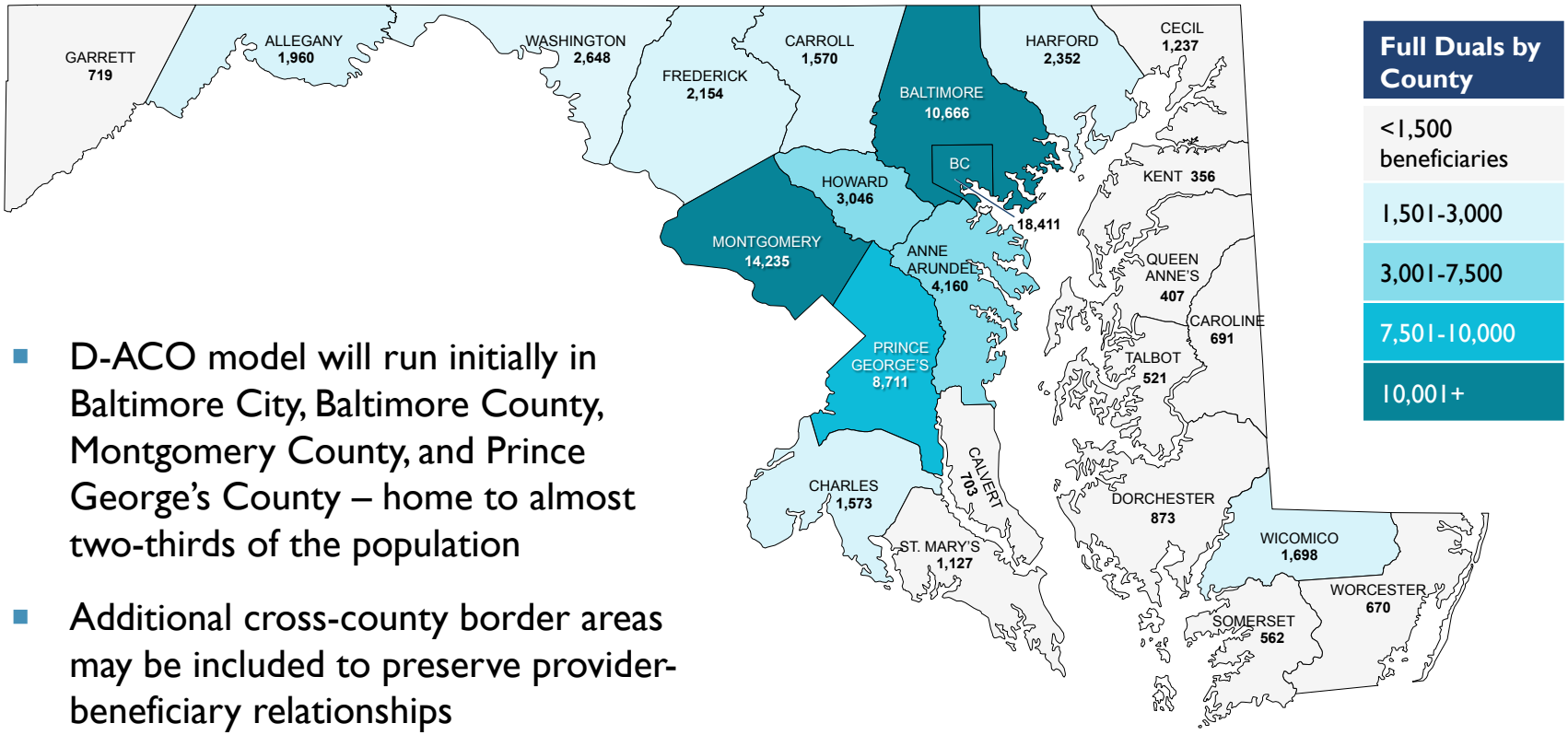
Primary Drivers

Health Home	Care Coordination	Ease of Use	Accountability
Continuous beneficiary care relationship with a principal provider	Seamless care handoffs between providers, across settings	Unified processes and reliance upon existing community resources	Incentives for quality and cost effectiveness across Medicaid & Medicare

Secondary Drivers

Health Home	Care Coordination	Ease of Use	Accountability
• Beneficiary chooses and remains formally linked to a Person-Centered Health Home (PCHH) suited to personal circumstances • PCHH is responsible for assessing needs, care planning and leading coordination of all care beneficiary needs • PCHH supported by ACO care management	• Beneficiary's medical, behavioral, LTSS and social service elements all considered in plan • Health data exchange enables real-time awareness and readiness as beneficiaries transit across settings of care • All setting-specific care coordinators sync up with PCHH to eliminate duplication or conflict	• Beneficiary's medical, behavioral, LTSS and social service elements all considered in plan • Health data exchange enables real-time awareness and readiness as beneficiaries transit across settings of care • All setting-specific care coordinators sync up with PCHH to eliminate duplication or conflict	• Care coordination is recognized as a function needing to be paid for • Providers rewarded for achieving quality and cost savings goals; moderate downside risk in ACOs • Medicaid and Medicare dollars combined to gain accountability for whole-person spending • Align with all-payer model

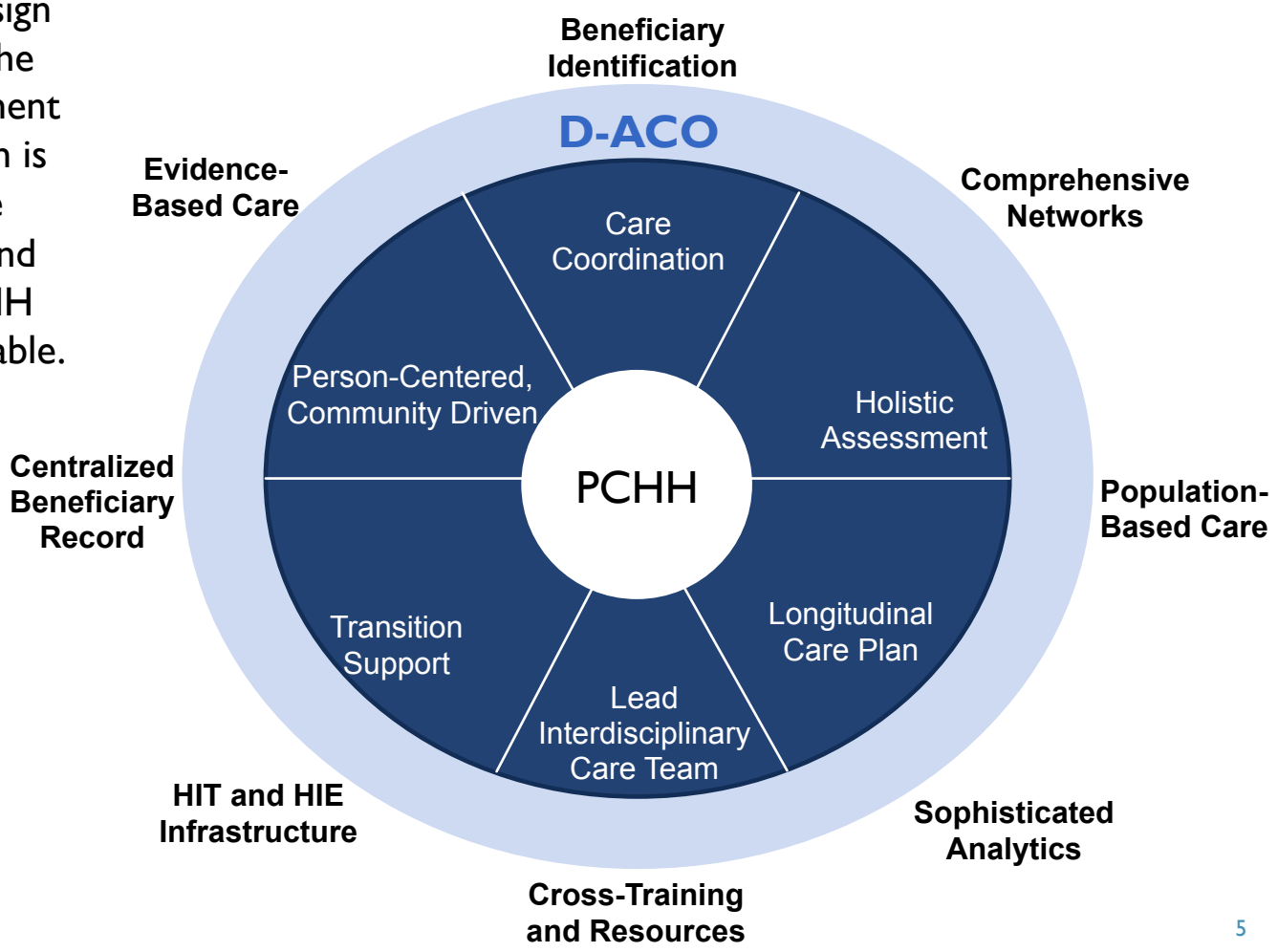
D-ACO WILL RUN IN MOST POPULOUS AREAS



- D-ACO model will run initially in Baltimore City, Baltimore County, Montgomery County, and Prince George's County – home to almost two-thirds of the population
- Additional cross-county border areas may be included to preserve provider-beneficiary relationships
- Potential expansion to wider area once concept proven viable

D-ACO AND PCHH ROLES

To achieve care redesign and transformation, the role of care management and care coordination is a responsibility of the D-ACO but shared and delivered by the PCHH to the extent reasonable.



BENEFICIARY-TARGETED MATERIALS

- DHMH will use the approved D-ACO-specific beneficiary materials for the counseling and designation process
- D-ACOs will use approved materials for ongoing communication and education of designated beneficiaries
  - Materials will allow D-ACOs to describe location, hours, services, network, and other common attributes of the D-ACO program and will afford an opportunity for each D-ACO to highlight its unique approach
- Materials will be translated into prevalent languages and will be culturally and disability competent

BENEFICIARY COUNSELING

- DHMH or a designee will provide counseling on the benefits of the D-ACO program as well as the information about the PCHH to which the beneficiary would be designated absent an affirmative choice
  - At least 60 days prior to the effective date of designation, DHMH or a designee will conduct multiple communication efforts including mail and/or telephone
- The counseling process will start with the beneficiary's selection of the PCHH; if the PCHH exclusively participates in a D-ACO, the PCHH election will serve as the D-ACO election, if non-exclusive, counseling till then continue to discussion of D-ACO election options
- Counseling will provide the PCHH and D-ACO options to the beneficiary based on his or her historical Medicare and Medicaid claims data, diagnostic history, and geographic location
- Individuals in the northern region (Baltimore City and Baltimore County) will be precluded from electing a D-ACO that operates only in the southern region (Prince George's County and Montgomery County) and vice versa

QUALITY MEASUREMENT OVERVIEW

- Goals
- Measure selection
- Initial reliance on MIPS-NQF measures
- Core Quality measures – Current NQF recommended
- ICD-10
- Transformation over time
  - Measures Under Development (MUD)
  - HCBS and Examples
- Approach to aggregating measure-level performance to calculate a D-ACO quality score

QUALITY MEASUREMENT

- Goals for quality measurement system
  - Protect beneficiaries
  - Ensure cost savings are associated with improved quality
  - Create alignment of measurement across programs
  - Case mix adjustment where applicable
- Quality measure selection strategy
  - Ensure coverage of key domains of care for dual eligible beneficiaries, including social factors and quality of life
  - Rely upon validated measures from credible stewards
  - Align measures and reporting requirements with other programs and minimize number to reduce reporting burden
  - Focus process measures on care coordination

QUALITY OF CARE FOR DUALS

- National Quality Forum (NQF) – Repository for systematically developed and evolving Quality Measures – uses expert panels for Measures Under Consideration (MUC) and Measures Under Development (MUD)
- "Advancing Person-Centered Care for Dual Eligible Beneficiaries through Performance Measurement" – 35 measures and, also recommended starter set of core measures August 2015
  - Cross cutting measures and generally not disease-specific
  - Minimize data collection burden
  - Alignment with other federal and state programs
  - "Measure Status Report" tracks each NQF approved measure: identifies Measure Steward, numerator and denominator, risk adjustment, data source, and more.
- The Quality Horizon – the future
  - electronic Clinical Quality Measures – eCQMs derived from electronic Health Records
- New Community Integration/LTSS focused measures are under development

DUALS CORE QUALITY MEASURES (1 OF 2)

Measure	Data Source	NQF #/ Measure Steward
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment	Claims/ E H R	4/NCQA
CAHPS Health Plan v 4.0 - Adult questionnaire	Beneficiary Reports	6/AHRQ
Controlling High Blood Pressure	Under Reconsideration NQF	18/NCQA
Preventive Care and Screening: Tobacco Use: Screening & Cessation Intervention	Claims/E H R /Paper or Registry	28/AMA Consortium
Medication Reconciliation - Post Discharge	Claims/E H R /Paper or Registry	97/NCQA
Falls: Screening, risk-Assessment, and Plan of Care to Prevent Future Falls	Claims/E H R /Paper	101/NCQA, AMA Consortium
3-Item Care Transition Measure at Hospital Discharge (Needs, responsibility and medications)	Beneficiary Reported Data	228/University of Colorado
Advanced Care Plan	Claims/E H R	326/NCQA, AMA Consortium
Preventive Care and Screening: Screening for Clinical Depression and Follow-Up Plan	Claims/Paper/Other	418/CMS, Mathematica, Quality Institute of PA
Documentation of Current Medications in Medical Record	Claims/Other/Registry	419/CMS, Mathematica, Quality Institute of PA
Adult Weight Screening and Follow-up	Claims/Other/Paper/ Registry	421/CMS, Mathematica, Quality Institute of PA
Follow-Up After Hospitalization for Mental Illness	Claims/E H R	576/NCQA

DUALS CORE QUALITY MEASURES (2 OF 2)

Measure	Data Source	NQF #/ Measure Steward
Timely Transmission of Transition record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care)	Claims/Other/Paper	648/AMA Consortium
Plan All-Cause Readmissions	Claims	1768/NCQA
Antipsychotic use in persons with dementia (New Measure)	Claims	2111/Pharmacy Quality Alliance
Sepsis - Appropriate treatment of MSSA (Methicillin-sensitive Staphylococcus aureus) Bacteremia (Note - sepsis measures are undergoing revision)	Claims/E H R	CMS 407/Infectious Disease Society of America
Diabetes Care for People with Serious Mental Illness Hemoglobin A1c (HbA1c) Testing	Claims (Only), Electronic Health Record (Only), Laboratory, Paper Records, Pharmacy	2603/NCQA
Diabetes Care for People with Serious Mental Illness: Medical Attention for Nephropathy	Claims (Only), Electronic Health Record (Only), Laboratory, Paper Records, Pharmacy	2604/NCQA
Diabetes Care for People Serious Mental Illness: Blood Pressure Control (<140/90 mm Hg)	Claims (Only), Electronic Health Record (Only), Paper Records, Pharmacy	2666/NCQA
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	Claims (Only), Electronic Health Record (Only), Laboratory, Paper Records, Pharmacy	2607/NCQA
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Control (<8.0%)	Claims (Only), Electronic Health Record (Only), Laboratory, Paper Records, Pharmacy	2608/NCQA
Diabetes Care for People with Serious Mental Illness: Eye Exam	Claims (Only), Electronic Health Record (Only), Paper Records, Pharmacy	2609/NCQA
HIV Viral Load Suppression	Laboratory, Other, Paper Records	2082/Health Resources and Services Administration - HIV/ AIDS Bureau
Atrial fibrillation and Atrial Flutter: Chronic Anticoagulation Therapy	Registry	1525/American College of Cardiology

DUALS QUALITY MEASURES UNDER DEVELOPMENT

Measure ID	Measure Title
3002	Ability to participate in social roles and activities (PROMIS)
3003	Access to counseling
3004	Access to Counseling or Treatment
3005	Access to home health care
3006	Access to medical equipment
3009	Admission to an institution from the community among Medicaid fee-for-service (FFS) home and community-based service (HCBS) users.
3029	All-cause emergency department utilization rate for Medicaid beneficiaries with complex needs (BCNs)
3083	Care Fragmentation
3088	Change in function over time
3094	Choice and Control
3112	Community Inclusion
3127	Days residing in the community
3162	Follow-up after all-cause emergency department visit for Medicaid beneficiaries with complex needs (BCNs) age 18 and older.
3168	Follow-Up care for adult Medicaid beneficiaries who are prescribed high-risk psychotropic medications
3183	Healthy days
3192	Hospitalization for Ambulatory Care Sensitive Conditions
3194	Hospitalization for severe pressure ulcers
3220	Instrumental Support
3291	Percent of Medicaid beneficiaries receiving buprenorphine who have a documented diagnosis of opioid use disorder (OUD).
3292	Percent of Medicaid beneficiaries with a diagnosis of opioid use disorder (OUD) who are prescribed a medication for treatment of OUD.
3343	Satisfaction with participation in social roles and activities (PROMIS)
3351	Self-efficacy
3353	Social Isolation (PROMIS)
3357	Standardized functional assessment
3363	Successful transition after long-term institutional stay among Medicaid fee-for-service (FFS) beneficiaries.
3364	Successful transition after short-term institutional stay among Medicaid fee-for-service (FFS) home and community-based service (HCBS) users.

QUALITY FUTURE METRIC DETAIL – ICD-10

Z59 Problems related to housing and economic circumstances

- Z59.0 Homelessness
- Z59.1 Inadequate housing
- Z59.2 Discord with neighbors, lodgers and landlord
- Z59.3 Problems related to living in residential institution
- Z59.4 Lack of adequate food and safe drinking water
- Z59.5 Extreme poverty
- Z59.6 Low income
- Z59.7 Insufficient social insurance and welfare support
- Z59.8 Other problems related to housing and economic circumstances
- Z59.9 Problem related to housing and economic circumstances, unspecified

Z60 Problems related to social environment
Z62 Problems related to upbringing
Z63 Other problems related to primary support group, including family circumstances
Z64 Problems related to certain psychosocial circumstances
Z65 Problems related to other psychosocial circumstances

QUALITY MEASURES – HCBS STATUS

Home and Community Based Services (HCBS) to Support Community Living – September 2016 NQF and its 22 person advisory committee proposes measures be developed and refined in eleven domains.

1. Service Delivery and Effectiveness - in accordance with service plan
2. Person-Centered Planning and Coordination – includes assessment
3. Choice and Control – personal freedom, dignity and self-direction
4. Community Inclusion – social connectedness
5. Caregiver Support for family caregivers
6. Workforce – cultural competencies and compensation
7. Human and Legal Rights – freedom from abuse and neglect; privacy
8. Equity – fair and just treatment; transparency
9. Holistic Health and Functioning – prevention and health promotion
10. System Performance and Accountability – Evidence-based practice; data for performance improvement
11. Consumer Leadership in System Development

NQF - "Quality in Home and Community-Based Services to Support Community Living: Addressing Gaps in Performance Measurement." September 2016 http://www.qualityforum.org/Publications/2016/09/Quality_in_Home_and_Community-Based_Services_to_Support_Community_Living__Addressing_Gaps_in_Performance_Measurement.aspx

SERVICE DELIVERY AND EFFECTIVENESS MEASURE CONCEPTS

Subdomain: Delivery	Source
Services are delivered in accordance with the service plan (SP), including in the type, scope, amount, duration, and frequency specified in the SP.	MLTSS NY, HI others
Percent of survey respondents who reported receiving all services as specified in their service plan.	MLTSS KS
The number of service hours delivered minus the number of service hours approved.	MLTSS DE

Subdomain: Person's needs met and goals realized	Source
Percent responding yes to: Do the services you receive meet your needs and goals?	NCI-AD
Percent strongly agreeing with: As a direct result of the services I received, I am better able to do the things I want to do.	MHSIP-ACS
Proportion of individualized Care Plans with goals unmet.	MLTSS NY
Percent responding yes to: Are services and supports helping you to live a good life?	NCI-ACS

General measures related to the domain	Source
Of the total number of scheduled (HCBS) visits for each type, by provider type; the percent that were: on time, late, missed.	MLTSS TN
Of the total number of late/missed visits for each service type, by provider type: the percent that were: member initiated; provider-initiated; due to weather/natural disaster.	MLTSS TN

PERFORMANCE MEASUREMENT

- Process of calculating aggregate quality performance scores for each D-ACO for shared-savings/losses calculation purposes
- D-ACO performance on each measure will be rated to ensure consistency
  - Uses manner similar to the Star Ratings cut points system in Medicare Advantage
- Summary ratings for each D-ACO will then be calculated by using a weighted average of the measure-level ratings
- Example calculation included in the following slides

QUALITY MEASUREMENT – DOMAINS AND LEVELS – EXAMPLE

Domain	Number of Individual Measures	Total Measures for Scoring Purposes	Total Possible Points	Domain Weights
Patient Caregiver Experience – Family Centered	8	8 measures	8	20%
Care Coordination/Patient Safety	10	10 measures, 1 double weighted	11	20%
Preventive Health	8	8 measures	8	20%
At-Risk Population	5	5 measures, 3 double weighted	8	20%
LTSS Measures (TBD)	5	5 measures	5	20%
Total in all Domains	36	36	40	

Quality Rating – Will transition from reporting to performance over two years

Highest = 90% - 100%
High = 75% - 89%
Acceptable = 50% - 74%
Less Than Acceptable = 0% - 49%

D-ACO PERFORMANCE SCORE - EXAMPLE

Beneficiary			Duals Core Measures Augmented							Total Score		
	Cohort	HCC Score	1	2	3	4	5	---→	36	Total Achieved	Total Possible	%
Beneficiary #1	2		1	0	1	2	NA		1	38	39	97%
Beneficiary #2	1		1	0	1	0	1		1	33	40	83%
Beneficiary #5000	2		1	1	NA	2	0		1	34	37	92%
D-ACO Total	(The D-ACO total score is the summed achieved divided by summed possible.)											91%

HCC Score = Potential risk adjustment

Duals Core - Individual Measure Scores

0 = Eligible, not achieved

1 = Eligible, achieved

2 = Eligible, achieved, double weight for this measure
(4 out of 36 measures are double weight)

NA = Measure not applicable

POPULATION-ADJUSTED BENCHMARKS

- Benchmarks will be adjusted based on the level of need of the attributed beneficiaries
- Possible cohorts:
  - Blended Nursing Facility Level of Care (NFLOC) comprised of Institutional and HCBS recipients
  - Community Dwelling (non NFLOC) beneficiaries
- Pre D-ACO mix of Institutional and HCBS beneficiaries (i.e., 60% Inst./40% HCBS) used to develop PBPM TCOC benchmark, with re-calibration after initial D-ACO attribution takes place.
  - Possibility of a risk corridor around the mix of Institutional vs. HCBS beneficiaries, to reduce the risk of significant differences between initial attribution and full experience period.
- Results in reduced incentive for unnecessary transitions to institutional placement

ADMINISTRATIVE CARE MANAGEMENT FEE

- Additional care management fee to supplement revenue from claims and shared savings
- Intended to ensure availability of intensive care management and coordination services without regard to timing or amount of shared savings
- Two Payments
  - Initial Care Planning Payment
    - One-time payment for completion of the care plan to compensate for higher outreach, engagement, assessment, and care planning costs (equal to 2 or 3 months of ongoing PBPM payment)
  - On-going PBPM – expected to equal no more than 2% of TCOC
    - Tiered based on beneficiary risk stratification
    - Payment begins 1st month following initial care planning payment and continue as long as beneficiary is designated to D-ACO and care plan continues to be managed and updated
    - No claim or encounter required following initial care plan

D-ACO RISK-SHARING

- Higher D-ACO sharing in outcomes as results deviate more from target
- Better financial result for D-ACO as quality rises
- No risk of loss for D-ACOs in initial two-year shake-out period

		Losses (Yr. 3 & After)			Savings		
	Actual Spend vs. Target:	> 5%	2 - 5%	0 - 2%	0 - 2%	2 - 5%	> 5%
D-ACO Quality Rating	Highest	20%	10%	0%	40%	50%	60%
	High	30%	20%	10%	30%	40%	50%
	Acceptable	40%	30%	20%	20%	30%	40%
	Less Than Acceptable	50%	40%	30%	0%	0%	0%

In years 1-2, a D-ACO has no downside risk; its share of any loss = 0%

Quality rating must be at least Acceptable for D-ACO to earn any savings award

D-ACO INCOME ILLUSTRATIONS (1 OF 3)

Hypothetical example 1 – Actual TCOC exceeds target

Suppose:

- A D-ACO gets 4,000 aligned beneficiaries
- The average care coordination payment is $60 PBPM, or $720 PBPY
- The TCOC target is $3,500 per beneficiary per month, or $42,000 PBPY
- The D-ACO loses 2.5% against the TCOC target and quality rating is Acceptable

Then:

- D-ACO receives $2,880,000 to support care coordination efforts in real time
- D-ACO's aggregate TCOC target = $168,000,000; care costs = $172,200,000

If Year 1 or Year 2:

- D-ACO is not required to pay any share of the $4,200,000 excess cost

If Year 3 or after:

- D-ACO owes 30% share of loss, or $1,260,000

D-ACO INCOME ILLUSTRATIONS (2 OF 3)

Hypothetical example 2 – Modest gain

Suppose:

- A D-ACO gets 4,000 aligned beneficiaries
- The average care coordination payment is $60 PBPM, or $720 PBPY
- The TCOC target is $3,500 per beneficiary per month, or $42,000 PBPY
- The D-ACO saves 1.8% against the TCOC target and quality rating is Acceptable

Then:

- D-ACO receives $2,880,000 to support care coordination efforts in real time
- D-ACO's aggregate TCOC target = $168,000,000; care costs = $164,976,000
- At year's end the D-ACO receives a 20% share of $3,024,000, or $604,800

D-ACO INCOME ILLUSTRATIONS (3 OF 3)

Hypothetical example 3 – Good gain

Suppose:

- A D-ACO gets 4,000 aligned beneficiaries
- The average care coordination payment is $65 PBPM, or $780 PBPY
- The TCOC target is $3,800 per beneficiary per month, or $45,600 PBPY
- The D-ACO saves 3.0% against the TCOC target and quality rating is High

Then:

- D-ACO receives $3,120,000 to support care coordination efforts in real time
- D-ACO's aggregate TCOC target = $182,400,000; care costs = $176,928,000
- At year's end the D-ACO receives a 40% share of $5,472,000, or $2,188,800

SPECIFIC STOP-LOSS RISK MITIGATION

- Specific stop-loss:
  - In reconciling the risk/reward opportunity at the end of each performance year, the most costly 1% of D-ACO attributed beneficiaries will be excluded
  - To account for the above when computing the baseline TCOC target, claims expenses will be truncated at the 99th percentile of population spending – that is, the 1% most costly people will be excluded
  - 1% exclusion will apply at the cohort level to avoid excluding appropriately high-cost institutional beneficiaries

SPECIFIC STOP-LOSS RISK MITIGATION

Cohorts	Unadjusted		Application of Stop-Loss to Remove Top 1% In Aggregate		Percent Impact of Reduction		Application of Stop-Loss to Remove Top 1% by Cohort		Percent Impact of Reduction	
	Dollars	PMPM	Dollars	PMPM	Dollars	PMPM	Dollars	PMPM	Dollars	PMPM
Nursing Facility	$634,364,709	$ 9,248.88	$ 559,699,144	$ 8,511.95	-11.8%	-8.0%	$ 598,205,644	$ 8,874.44	-5.7%	-4.0%
HCBS	$240,668,422	$ 4,424.72	$ 227,894,543	$ 4,231.64	-5.3%	-4.4%	$ 225,697,673	$ 4,201.22	-6.2%	-5.1%
Community Dwelling	$535,663,041	$ 1,548.43	$ 486,804,757	$ 1,413.64	-9.1%	-8.7%	$ 463,335,188	$ 1,350.79	-13.5%	-12.8%
All - Total	$1,410,696,173	$ 3,008.40	$ 1,274,398,444	$ 2,746.71	-9.7%	-8.7%	$ 1,287,238,505	$ 2,773.38	-8.8%	-7.8%

Notes:

Figure above reflects total Medicare/Medicaid spend in CY13 for target Dual populations, residing in Baltimore City, Baltimore County, Montgomery County, and Prince George's County.

"Remove Top x%" reflect the impact of removing both member months and total dollars for members with the top x% of spend in each county (Either across all populations as noted by "Aggregate", or by "Cohort"), respectively (based on Medicare and Medicaid spend)

NEXT STEPS

- Focus of next year will be development and submission of waiver document
- Discussions will use concept and goals identified to draft operational detail
- Stakeholder engagement will continue next year